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The Work Behind the Work Requirement: CMS Imposes Sweeping Medicaid Community Engagement Rule

Key Takeaways

- On June 1, CMS released an interim final rule implementing the new Medicaid community engagement requirement (i.e., work requirement) as a condition of Medicaid eligibility for adults aged 19-64 with access to Medicaid coverage as a result of Medicaid expansion under the Affordable Care Act.
- States will need to build and pay for substantial operational infrastructure, eligibility system modifications, verification processes, outreach materials and reporting mechanisms before the January 1, 2027, implementation deadline.
- While the rule is directed at state Medicaid agencies, health care providers, managed care organizations, community-based organizations, and other entities serving Medicaid populations should prepare for increased rates of uncompensated care as impacted beneficiaries face additional eligibility and enrollment hurdles.
- Medicaid eligible adults who are medically frail face increased requirements to demonstrate statutory exclusion from community engagement/work requirements under the rule.
- The rule may exceed the statutory authority granted to CMS by H.R. 1, and challenges from states, advocacy groups, and other key stakeholders are likely.

On June 1, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) implementing new statutory work requirements for Medicaid expansion beneficiaries. States must implement the IFC no later than January 1, 2027.[1] Expansion adult Medicaid applicants and enrollees will be required to demonstrate approved community engagement, unless they fall within an exclusion or short-term hardship exception.

The IFC allows individuals to meet that standard through 80 hours per month of qualifying work, community service, approved work programs, or a combination of qualifying activities. Half-time (or greater) enrollment in an educational program, monthly income equal to at least 80 hours multiplied by the federal minimum wage, or a separate income calculation for seasonal workers also qualifies. The IFC also addresses several critical questions that remained open post-H.R. 1, including how CMS defines exclusion criteria (e.g., what constitutes “medical frailty”), what constitutes community service, what

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verification is needed when data sources are unable to verify a person's compliance or exclusion and what data states are required to report.

Now that CMS has released formal guidance, states have only seven months to process the guidance and re-tool systems currently under development. Given this truncated timeline, many states will struggle to modify, test, and deploy the processes and systems necessary to comply with the January 1, 2027 go-live date. For states like Nebraska, which implemented work requirements early, there is risk that implementation prior to CMS guidance will be noncompliant. The significant administrative burdens and costs associated with the federal requirements will put additional stress on Medicaid beneficiaries, states, and Medicaid providers. We can expect to see implementation errors and, as a result, potential loss or disruption in Medicaid coverage for beneficiaries and increases in uncompensated care.

How CMS Defines "Medical Frailty" Under the Medicaid Community Engagement Requirement

Under H.R. 1, "medically frail" individuals are excluded from the community engagement requirement. H.R. 1 specified exclusion categories to include individuals who have substance use disorders, disabling mental disorders, certain physical, intellectual, or developmental disabilities (e.g., blindness), and serious or complex medical conditions.

The IFC goes beyond the statutory "medically frail" definition by requiring states to consider whether the frailty would significantly impair an individual's ability to comply with the community engagement requirement. CMS commentary describes these individuals as "potentially medically frail" and imposes additional requirements for the community engagement exclusion to apply. States must implement processes to identify and verify the impact of medical frailty on community engagement compliance, potentially shifting that verification burden onto the medically frail beneficiary. The IFC does not permit automatic diagnosis-based exclusion, and requires an individual determination of frailty with at least annual reverification**,** although states may impose more frequent verification requirements and states are required to revalidate *eligibility* every 6 months. Accordingly, states must regularly consider and verify that an individual's condition significantly impairs their ability to satisfy the community engagement requirements, rather than automatically excluding every person with a specific diagnosis or prior classification as medically frail.

CMS would require states to operationalize this exclusion through defined procedures, such as auditable and justifiable lists of diseases, diagnoses, disorders, or other conditions that may support a medical frailty determination *and* a case-by-case procedure for individuals. For providers, this means that clinical documentation will be important not only when a patient has a state-designated condition, but also when the patient's diagnosis, functional limitations, treatment needs, or other circumstances support an individualized medical frailty determination.

For providers, the medical frailty exclusion will likely become one of the most significant protections against coverage loss for vulnerable Medicaid beneficiaries, but new verification requirements will increase the administrative burden on providers who assist beneficiaries who seek this exclusion. Providers will likely be asked to furnish clinical documentation supporting medical frailty determinations, including documentation regarding diagnosis, severity, functional limitations, treatment needs, and the impact of a condition on a patient's ability to work or participate in community activities. It is unclear if CMS's expansion of the requirements to demonstrate medical frailty in the IFC exceeds its authority under H.R. 1, and this portion of the IFC is expected to draw significant comments and potential challenges from Congress and the public.

What Qualifies as Community Service Under the Medicaid Community Engagement Requirement?

Beyond traditional employment, the community engagement requirement can also be satisfied by community service. CMS defines community service as unpaid work performed through a structured program for the direct benefit of the community under the auspices of a public or nonprofit organization. Approved community service cannot serve a partisan purpose and must have a process in place to document and verify participation. Informal volunteer activities generally will not satisfy the requirement.

Notably, community service does not have to be voluntary. Court-ordered community service or community service performed to satisfy another legal obligation may count toward the requirement, provided it otherwise meets the definition and is performed through a qualified structured program.

States Face Extensive Verification, Notice and Medicaid Data Reporting Obligations

The IFC requires states to rely on electronic data sources and *ex parte* verification processes before requesting information from beneficiaries. States must establish systems and procedures to verify compliance, exclusions, and exceptions using available data whenever possible. CMS also directs states to use claims and encounter data, educational records, employment information, and data from other state and federal agencies to support eligibility determinations.

The rule creates extensive notice requirements, including outreach obligations and formal noncompliance notices. Beneficiaries must be given at least 30 days to demonstrate compliance or establish that they qualify for an exclusion or exception before coverage may be denied or terminated. If an individual is disenrolled for failing to meet the work requirements, the individual may reapply for Medicaid coverage.

What Comes Next for Providers Navigating Medicaid Community Engagement Requirements

Although Medicaid providers are not directly responsible for enforcing the community engagement requirement, the rule may have significant downstream effects on provider operations and Medicaid coverage continuity. Providers should be alert for patients experiencing Medicaid coverage or enrollment issues or questions and should ensure their Medicaid eligibility processes account for potential disruptions in coverage. Providers should maintain evidence of Medicaid eligibility verifications to help guard against the possibility of future audit findings alleging a lack of coverage or eligibility.

Providers across the country can also learn from the implementation of these requirements in states that have started early, such as Nebraska, and should utilize this experience to work with their own state programs on implementation of these requirements and improve their own internal processes and procedures in advance of January 1, 2027.

Public comments on the IFC must be received by July 31, 2026. For more information about the rollout of the federal community engagement requirements or Medicaid compliance in general, please contact Jennifer Evans, Ryan Thurber, Kathy Schaeffer or your regular Polsinelli attorney.

[1] H.R. 1, Pub. L. 119-21 (July 4, 2025).